State of Rhode Island
WAGE TRANSCRIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

This form will not be accepted for filing unless all information is completed.

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

3. INSURER COMPLETE:

This wage transcript is submitted to support a:

☐ **Discontinuation of benefits.** The employee has returned to work at a wage equal or greater than he or she earned at the time of the injury.

☐ **Reduction of benefits.** The employee has returned to work at a wage less than he or she earned at the time of the injury.

Date benefits were discontinued or reduced: _____

Pre-injury average weekly wage, **not** including overtime: _____

4. EMPLOYER COMPLETE:

Post-Injury Earning Information -- WEEKS MUST BE CONSECUTIVE

	Period Start Date	Period End Date	Number of Hours Worked	Payment Rate	Amount of Earnings
Week 1					
Week 2					

Employer Name: _____

Address: _____

City, State Zip: _____ Phone: _____

Employer Signature: Date:

RIGL § 28-35-47 allows indemnity benefits to be discontinued upon filing of a wage transcript showing the employee returned to work for at least two consecutive weeks and earned as much or more than earnings at the time of the injury, excluding overtime.

Top of form:

- Correction Box: Check if this document is correcting a document previously filed.
- Claim Administrator File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

1. Employee Information. The claim administrator completes section 1.
   - SSN: enter at least the last 4 digits of the employee's social security number or the employee ID number assigned by DLT. DO NOT use a fictitious number.
   - Name: enter the employee's first name, middle initial and last name.
   - Address: complete the employee's street address, city, state and zip code.
   - Phone: provide the employee's phone number if available.

2. Claim Information. The claim administrator completes section 2.
   - Employer: enter the company name of the injured worker's employer at the time of the injury.
   - Insurance Co: enter the name of the licensed insurance company or self-insured employer.
   - Claim Administrator: enter the company name of the insurer or third party administrator, whichever party is handling this claim.
   - Injury date: enter the injury date.
   - Incapacity date: Enter the incapacity date, which is the first full day that the employee was unable to work.

3. Insurer Complete: The claim administrator completes section 3.
   - Check the box to show that benefits are being discontinued or reduced.
   - Enter the effective date that benefits were discontinued or reduced.
   - Enter the amount of the pre-injury average weekly wage EXCLUDING overtime.

4. Employer Complete. The post-injury employer completes section 4.
   - For each of two consecutive weeks, enter the week start date, week end date, number of hours worked in the week, rate of payment and amount of earnings.
   - List the post-injury employer business name, address, city, state, zip code and phone.
   - The post-injury employer must sign and date the form.
   - The employer should return the form to the claim administrator.

Claim administrator files the Wage Transcript with The Department of Labor and Training with copies to the employee and the employee's attorney.